Corkhill Family Response to the WorkCover NSW Determination (File No: 2009/022056) into the Workplace Death of Michael Corkhill

Prepared on behalf of The Corkhill Family by Dr Giovanni Cordeiro and Ms Janet Bishop

We, the members of Michael Corkhill's family feel disappointed in the WorkCover NSW investigation and in our opinion, believe WorkCover NSW:

1. Constructed a determination based on limited background research and a flawed approach to the investigation;
2. Terminated the investigation prematurely;
3. May have attempted to placate an individual(s) from the workplace being investigated, ie On Track Community Programs;
4. Showed disregard for the life of the deceased individual.

The determination of WorkCover NSW lulls the community and those facing similar workplace safety concerns into a false sense of security by suggesting that safety can be achieved through the use of a company car or giving movement indications on a white board.

It is baffling that whilst WorkCover NSW has determined work place practices at On Track were lacking prior to 27th June 2009, it appears that WorkCover NSW has made a concerted effort to indicate that Michael only had himself to blame for his death. The finding is extremely distressing to the family members of Michael Corkhill and is a miscarriage of justice by WorkCover NSW.

We provide the following response to the WorkCover briefing notes received through Freedom Of Information.

Contents

I. Refute on Findings by WorkCover

WorkCover in its determination to discontinue the investigation listed the following four reasons. That the victim:

1. Did not indicate his movements on a whiteboard
2. Did not use a company car
3. Did not inform the on-call manager
4. Was visiting after-hours

The above four reasons provided appear as an effort to place blame on the victim and to hastily construct a conclusion to divert the need for further investigation. In addition, it provides a false impression that the victim deserved the consequences.

We will examine the validity of each of the above points here as well as provide background information on policies that were poorly adhered to at On Track Community Programs.

1. Did not indicate movements or perform a safety checklist

The above reason provided appears to suggest that if a movement message or safety checklist was indicated, assistance could and would have been rendered at the appropriate time and the incident could have been avoided. The fact is, only a single staff is rostered at any one time and the Refuge shift that Michael was on would have ended at 8:30am the following morning (ie on the 28th of June 2009). Only then, would the relief staff have arrived and noticed his absence.

The whiteboard at the time of the incident and used to indicate movements was located ***within*** the staff room of the Refuge which no client has access to and no other staff member would have seen until they reported for work the next day. Note that there is *only one* staff member rostered per location and therefore there was no

other staff member at the Refuge who could have noted Michael's movements that night. Hence, regardless of any movement indication on the whiteboard or any other location within the Refuge, it is extremely unlikely that the incident would have been prevented.

2. Did not use a company car

At the time of the incident, Michael was ***not*** in any vehicle but in the unit of the assailant. It would have been appropriate to state this procedural failure had the victim been in a vehicular accident. In addition, the unit is within walking distance of the Refuge where Michael was stationed and he could have chosen to walk if desired. Hence, regardless of which car he was driving, the ownership and registration details of the car would not have saved his life. In **Appendix I**, details are provided that indicate it was not uncommon for Michael to use his private vehicle to carry out work related tasks.

3. Did not inform the on-call manager

The on-call manager for the evening was Roberta Brooks. Roberta is a junior staff member at the company and was still being trained by both Michael Corkhill and Peter Mitchell for her role as a HASI worker. Colleagues had expressed surprise at the selection of Roberta to the role of on-call manager. Had Michael contacted Roberta, he would have had to provide Roberta answers to any questions or concerns he might have had. In addition, Michael was in effect attempting to carry out his duties at the Refuge, by briefly dropping off medication to the refuge client, Ebony Zeeta Kennedy. This would have been a task that would have been approved as it was *part of his duties* for the evening.

4. After hours visits

The suggestion that 'visits' after hours pose a greater threat to safety is suggestive that mental health is a condition that affects an individual at specific times of the day. It suggests that between the hours of 8:30am and 4:30pm, a person suffering mental illness is

generally placid and unlikely to behave in a manner contrary to acceptable community standards, whilst between the hours of 4:31pm and 8:29am the following day, behavioural patterns are significantly and negatively altered. The mental health of a patient is not affected by the hour hands of a clock.

However, as part of unenforced policy, it should be noted that after hours visits was not an inconsistent activity that was strictly forbidden. It is known that visits to a particular HASI client after hours (between 6 and 6:30pm) for the express purpose of medicating the client to fulfil their Community Treatment Order was a regular occurrence. This was known to the manager, Ann Marie Bowen (See **Appendix I**).

In a recent incident involving the workplace death of a security guard whilst on duty delivering cash (Reference: ABC News, 7 June 2010: Security guard killed in Sydney CBD ambush), it can be assumed that procedures such as the use of a company vehicle (Armoured Vehicle) and movement notifications were followed. However, this did not prevent the homicide death of the individual. In the case of On Track, it is hence necessary to look at wider workplace practices that had led to the incident.

II. Lismore Branch Manager, Ann Marie Bowen

A. WorkCover Interview

The interview response provided by the Lismore branch manager, Ann Marie Bowen, appears to contradict common practice at the Lismore branch of the organisation.

1. Questioning in relation to cross-program interaction

The following is an excerpt from the WorkCover interview with Ann Marie Bowen.

> WC: What policy or procedure does the company have with regard to persons interacting between different locations during their shift?
>
> AB: Not supposed to do this.
>
> WC: Is this documented?
>
> AB: Yes, either work at the refuge, mandarra, as an outreach or HASI worker. It is not written because you don't do it.

Legend: WC = WorkCover District Co-ordinator, Paul Irwin
AB = OnTrack Lismore Manager, Ann Marie Bowen

Cross-program interaction during a work shift is highly common and unavoidable. The following are a small list of examples where this has occurred / still occurs. Validation of these statements can be obtained through interviews with staff or checking documented records at On Track.

i. Each Tuesday, as a voluntary activity to encourage interaction of all On Track clients in the Lismore area, a lunch time get together is organised. The day being known as "**Shed Day**". In this event, staff rostered for the various On Track programs would ferry clients, be they under their care for the day or otherwise, to the On Track 24 hour respite residence, Mandarra, located on

Ballina Road in Lismore. Staff performing duties across the various programs are encouraged to attend. It is also known that ***non***-On Track clients would attend.

ii. In early 2009, On Track staff member, Kristine Uebergang in charge of the Housing Program was stood down by the manager, Ann Marie Bowen. Michael Corkhill was tasked by Ann to *simultaneously* handle his area of concern (HASI) as well as that of the Housing Program. Tasks he was requested to handle include but are not limited to: enforcement of Community Treatment Orders; delivery of medication; and ferrying of clients. At this moment, it might be of value to re-read above, the boxed interview response of the Lismore branch manager.

iii. Peter Mitchell on the day of the incident, brought both a Refuge and a HASI client to Tallows beach (date: 27th June 2009). This information was provided to WorkCover in an On Track Community Programs Incident Report as prepared and signed by Leone Crayden (CEO On Track Community Programs) on 29 June 2009.

iv. During the Christmas holiday period, as staff prepare for the Christmas festivities and absences, the shortage of staff requires that staff on duty check on and ensure that the needs of clients across the programs are not neglected. These cross-program interactions are approved by the Lismore manager, Ann Bowen.

A note prepared by Michael in December 2008 relating to the handling of clients for Christmas day lunch and the subsequent Christmas / New Year holidays, suggest a high level of cross-program interaction. This note is available on request.

v. When a staff member calls in sick, a concerted effort is made to locate a replacement for the shift. On the occasion where a replacement cannot be obtained, two alternatives are presented:

a. the staff member coming off the shift may be required to remain and fill the vacant shift, effectively working a 24 hour stretch (against OH&S regulations?);

b. the shift is left vacant and a staff member rostered on a *different* program asked to check in on clients.

In addition, the response by Ann Bowen to the question, "Is this documented?" is indicated with a, **"Yes, ..."** , which is indicative of the procedure being *documented*. This response is then immediately followed by the words "It is ***not written*** because you don't do it". WorkCover NSW may wish to determine how a procedure *is documented* when it is *not written*?

Summary: The statements made by Ann Marie Bowen in her interview with WorkCover appears to show a certain degree of discrepancy between reality (as approved by herself) and her recollection of company practice during the WorkCover interview.

B. Supervisory Capability of Ann Bowen

Interviews with staff would reveal the difficulty Ann Bowen faced in correctly supervising staff. Under the Occupational Health and Safety Regulation 2001, Chapter 2, Clause 14 states:

Employer to provide supervision

(1) An employer must ensure that the employer's employees are provided with reasonable supervision necessary to ensure the health and safety of the employees and any other persons at the employer's place of work.
(2) The employer must ensure that the supervision is undertaken by a competent person.
(3) In determining the nature and extent of necessary supervision, the employer must have regard to the competence, experience and age of each employee.

A thorough investigation would have revealed the heavy personality disagreements between the Lismore branch manager (Ann Marie Bowen) and the CEO (Leone Crayden) that led to the branch manager ignoring staff concerns. These disagreements are a result of On Track's 'take over' (words as used by Leone Crayden in a meeting with Giovanni Cordeiro) of MHARS in which Ann Bowen was the most senior staff member. See e-mail statement submitted by Kristine Ubergang on 29 March 2010.

In addition, whilst difficult to accurately ascertain, there is a longstanding allegation with regard to the issue of heavy alcohol consumption that may have impeded Ann's ability to correctly supervise. Again, interviews with staff may reveal the extent of the issue.

III. Inadequate Interview Coverage

The family of the victim would like to draw attention to the inconsistent and poor interview strategies employed by WorkCover NSW. This is particularly evident in the failure to interview as many staff as possible given that the employee level at the Lismore office is not extensive and that staff had expressed a desire to be interviewed.

The following points are raised that support the above allegation:

1. Statements from only two non-management staff

Documents obtained through FOI show only two interview transcripts with Lismore non-management staff: Catherine Delaney and Roberta Brooks, both of whom are junior staff with little familiarity with the history of the workplace.

Whilst a statement from Ann Marie Bowen was taken, consideration needs to be given to the fact that she is the Lismore manager and any revelation of poor workplace practices will be a direct reflection on herself.

A statement was provided by Leone Crayden, the CEO of On Track. This statement appears to have been an internal incident report. Again, it needs to be considered that statements prejudicial to the good name of the company are not likely to be readily made to an investigating body by the CEO of a company.

2. No record of interview with key HASI worker

A one-on-one interview was carried out with Catherine Delaney as she was the staff member on duty at the Refuge on the 27th June 2009 between the hours of 8:30am and 4:30pm.

It seems unusual that whilst WorkCover NSW followed the line of investigation focussing on the HASI client, David Regan Rodriguez,

a one-on-one interview was not granted to the primary carer, Peter Mitchell, for the HASI client on the day in question.

It is no longer possible to interview Peter Mitchell as he is now deceased.

3. Interview of Peter Mitchell together with the CEO

It is understood that Peter Mitchell did meet with the District Co-ordinator (Ballina) together with the CEO of On Track. However, no interview transcript appears to be available in the documents obtained through FOI.

In a separate interview with Peter Mitchell by Giovanni Cordeiro, Peter indicated that he felt uncomfortable with expressing his views and concerns in the presence of his CEO during the meeting with the District Co-ordinator (Ballina). He made the indication that he had hoped to speak with the District Co-ordinator (Ballina) again privately. It appears that this did not occur.

4. Failure to interview other staff

Senior non-management staff with a greater insight into the history and running of the organisation were never interviewed, despite two known attempts at informing WorkCover NSW that these staff had concerns about not being interviewed.

The two recorded occasions that WorkCover NSW was informed were:

i. On 14 Sep 2009 approximately a week after meeting with the District Co-ordinator (Ballina), Dr Giovanni Cordeiro submitted a written statement to the District Co-ordinator. In this statement, a list of six staff members with contact details was provided. WorkCover NSW was informed that these persons had each given express permission to be interviewed and were keen to provide their statement.

Whilst it was indicated by WorkCover that the staff would be interviewed, from WorkCover records, it appears that no interviews were carried out.

ii. On 6 October 2009, WorkCover NSW received a letter dated 1 October 2009 and submitted by Ms Punita Boardman, Regional Organiser of the Australian Services Union relaying the concerns by staff at not being interviewed. It appears that this letter was ignored as no subsequent interviews were carried out.

By not obtaining the statements of staff members, WorkCover NSW failed to obtain crucial information pertaining to the true work culture at On Track.

5. Apparent failure to note statements provided by staff

A proactive stance was taken by two staff members who desired to be interviewed by WorkCover. The two individuals (Julie Neary and Kristine Uebergang) contacted the District Co-ordinator (Ballina) via phone to request provision of a statement. Both were prompted to lodge their statements via email instead. It does not appear that the statements provided by these staff members were taken into consideration through follow ups.

In addition, when staff member Kristine Uebergang contacted WorkCover on 18 March **2010**, she was informed that the investigation was ongoing and that her statement would be referred to. However, WorkCover NSW had on 17 December **2009**, closed the investigation deciding that no further investigation would be carried out.

6. Lapse in interview time

Over one month had lapsed between the incident time and the first set of interviews conducted by WorkCover NSW.

IV. Apparent Disinterest Shown by WorkCover NSW

Whilst it is not possible to fully prove the point, a number of comments and apparent non-occurrence of investigation lines point toward the allegation of a disinterest. These are listed below and assumed here to have truth unless proven otherwise:

1. Failure to fully communicate with Lismore police

The District Co-ordinator (Ballina) on two occasions (once on 4 September 2009 and a second on 1 April 2010) indicated that he had no interest in the police investigation, claiming that the police investigation was of no relevance to WorkCover.

Whilst the police were contacted two days after the incident when little information was available, no further attempt was made to contact them until 13 April 2010, four months after the decision to discontinue further investigation was signed off on. In failing to cooperatively communicate with the Lismore Police, WorkCover NSW failed to determine the reason Michael had visited the unit at Marilyn Street, hence failing to lead the investigation in the appropriate direction.

The CEO Briefing Note by WorkCover on 17th Dec 2009 indicates:

i. "Specific details of the incident are unknown";

ii. the matter to be "still an ongoing Police Investigation".

The above comments were made despite the fact that no attempt at communicating with the police was made. WorkCover NSW would have been unable to determine the "specific details" as it did not make an attempt to obtain these details from the police. If an attempt was made, WorkCover NSW would have realised that prior to 17 December 2009, the Lismore police had completed its

investigation and all files pertaining to the case had been submitted to the Department of Public Prosecutions (DPP) in Lismore. Yet, WorkCover NSW made the claim that the police investigation was "still ongoing". It could be alleged that these statements were made in an attempt to:

i. conceal a failure to properly co-operate and obtain crucial and relevant information from the police;

iii. divert the provision of factual information to the acting CEO.

The briefing notes to the acting CEO were needless to say, brief and devoid of information. It provides no content of substance that would have allowed the acting CEO of WorkCover NSW to have made an informed decision in relation to the incident.

An investigation protocol produced by WorkCover and published in January **2004**, states:

> "Both agencies (ie Police and WorkCover) will, in all cases, liaise and co-operate with each other. Cases which will benefit from a joint investigation are to be identified as early as possible to permit the most efficient use of resources. Any investigation, whether joint or otherwise, requires both the Police and WorkCover, given their separate and distinct coercive powers arising under statue and the common law, to co-operate to the fullest extent possible in the exchange of information necessary to progress each agency's investigation to completion."

2. Failure to interview staff

As indicated in Section III above, staff with relevant knowledge of the company were ignored despite a statement made by the District Co-ordinator (Ballina) to both Giovanni Cordeiro and Janet Bishop claiming that he knew little about the mental health sector.

3. Attitude of the District Co-ordinator (Ballina)

Family members found the manner of the District Co-ordinator (Ballina) to seem extraordinarily cavalier, condescending and defensive. He also seemed reluctant to meet with Michael's partner when contacted in August 2009. A significant effort was made to obtain a meeting with the District Co-ordinator (Ballina).

4. Failure to determine the character of the victim

No interview conducted by WorkCover NSW showed that an attempt was made to determine the true character or work ethic of the homicide victim, Michael Corkhill; or to establish the reasons why he might have chosen to assist Ebony Zeeta Kennedy (not Regan Rodriguez) at the time.

V. Focus of Investigation

In the second paragraph of the WorkCover CEO Briefing Note of 17 December 2009, under the heading of **BACKGROUND**, the following statement is made:

> On Saturday 27 June, at around 4:30pm, when Mr Corkhill as a Mental Health Support Worker at The Refuge (one of On Track's two 24-hour residential facilities at Lismore) he gave no indication that he intended to visit the home of a client later in the shift. Later on that evening, Mr Corkhill travelled to the residence of David Regan Rodriguez, a client who had been diagnosed with Bipolar Affective Disorder.

The statement highlights the failure to focus on the actual reason for Michael's visit to the unit at Marilyn Street. It suggests that the victim's intention was to visit unannounced, the **HASI** Program client David Regan Rodriguez. Police investigations reveal that the reason for visiting the unit was to attend to the needs of Ebony Zeeta Kennedy, a client of the **Refuge** Program located at Whyralla Road, where Ms Kennedy is a client. Michael had been rostered at the **Refuge** on the night. This information was made available to the family of Michael Corkhill in early July 2009.

We assert the above allegation of incorrect focus based on the following points:

1. The focus of questioning of the only three staff interviewed by WorkCover centred on "cross program" visits.

2. No line of questioning during interviews referenced the reasons as determined by the Lismore Police investigation, which was the delivery of medication to Ms Kennedy.

3. There was no consideration of ***why*** Michael had 'visited' the unit. Hence, the line of investigation had failed to consider the following factors on the night in question. Namely:

    i. Michael's tasks and responsibilities;

ii. The list of clients for whose care Michael was responsible.

Ebony Zeeta Kennedy, was and still is a client of the Refuge. She is NOT a HASI client. Whilst the person she was temporarily living with was a HASI client, Michael was ***not*** visiting this client. Police interviews with Ebony Zeeta Kennedy indicate that Michael was either bringing medication to Ebony Zeeta or responding to a distress call by her.

Hence, despite the frequent occurrence of cross-program interaction (see Section II), a cross-program visitation was *not the intent* of Michael on the night. In addition, based on the police determination of Michael's reason for being at the Unit, it would have been acceptable for Michael to run the medication over to Ebony Zeeta without going through any extended checks.

According to On Track policy:

> **2.18 Residential Services – Home Visits**:
>
> 3. Where at all possible unannounced visits should be avoided. Possible exceptions to this 'rule of thumb' may include:
>   - "Doorstop" visits for the brief exchange of messages or information
>   - The visit is undertaken at the express invitation of the consumer and
>   - Genuine emergencies and crisis calls

The police report indicates that Michael brought medication to Zeeta, which would be classified as a brief exchange of 'message or information'. There is also an indication that Michael may have responded to an emergency call from Zeeta although phone records are not available.

There has also been a failure to determine if Duty of Care by the employer (in particular, by the On Track Lismore branch manager, Ann Bowen) was provided. Under the WorkCover OH&S Act 2000, Duty of Care lists the following four points:

- Systems of work are safe;
- Equipment is safe and properly maintained;

- Employees receive health and safety information and training
- Employees are properly supervised;

The final point above was never ascertained by WorkCover NSW through proper interviews with staff, in spite of a statement being provided by Kristine Ubergang on 29 March 2010.

VI. Assumption of On Track's Public Interest Role

The WorkCover "Serious Incident Review Form" of 11 August 2009 indicates:

> "The entity [ie On Track Community Programs] is a non-profit organisation, providing a necessary community service. It would not be in the public interest to investigate/prosecute diverting resources from future services."

The above decision was made within two months of commencement of WorkCover's investigation and suggests an unknown desire to divert responsibility away from the Organisation.

The message this decision sends to both On Track and similar NGOs is one where such organisations need no longer consider their responsibilities in OH&S as failure to provide a safe working environment results in the mere inconvenience of being case-managed, and actions that result in the unnecessary loss of human life are therefore of minor consequence.

As funding is a highly valued commodity in such organisations, the message that WorkCover should send is that received funding should be protected by providing a safe working environment for staff and the shedding of responsibility has serious consequences including the risk of loosing future funding resources.

It would be helpful if WorkCover NSW was able to determine if the employer was in contravention of the provisions of the OHS Act 2000? If the organisation had contravened the act, it would be helpful if WorkCover NSW is able to explain how it is in the public interest to allow this ***negligence to go unrecognised or unprosecuted***.

For example:

1. How is it in the interests of not only Michael but all other workers in this industry to be actually unprotected by the OH&S Act?

2. How is it in the interests of the consumers in this industry to be serviced by organisations that are not held accountable under the OHS Act?

3. How is it the interests of the wider community who rely on these organisations to care for their mentally ill relatives, that organisations are not held accountable under the OHS Act?

Case-management only affects On Track Community Programs. It should be recognised that On Track is not the only provider of Mental Health support programs in NSW. There are numerous such providers, each with their own interpretation of safety in the workplace. Workers in the Mental Health sector have been lobbying their employers for greater safety as it is recognised that homicides and non-fatal serious injury (that could have resulted in death) resulting from systemic issues in the workplace is not uncommon (Tracking Tragedy 2008 – Fourth Report of the NSW Mental Health Sentinel Events Review Committee. Table 9, page 52). WorkCover NSW in its determination has missed the opportunity to play a critical and important role in encouraging enhanced safety standards throughout the Mental Health sector. There will be providers of Mental Health services that will continue to assume that as long as a homicide or death does not occur in their organisation, there will be little need to implement enhanced Occupational Health and Safety standards, particularly as these organisations will now be aware that failure to do so will only attract the inconvenience of case-management. The actions of WorkCover NSW serve to contradict the NSW Health Policy Directive on Zero Tolerance Response to Violence in the NSW Health Workplace (Document Number: PD2005_315).

VII. Expectations of WorkCover by Family Members

The decision not to proceed with a full investigation of this case was signed off by the ***acting*** CEO of WorkCover in December 2009 and based on limited information provided. The seriousness of this case (a death due to homicide has occurred) cannot be more highly emphasised and it would be appropriate for the case to be reviewed and signed off by the current CEO. It would also be appropriate to provide accurate information to the current CEO so that a considered decision can be made.

In addition, the family of the victim strongly requests the following:

1. That WorkCover NSW provide an unequivocal assurance that a **full, proper and thorough investigation** be carried out into the workplace practices of On Track Community Programs that led to the incident;

2. That WorkCover NSW work co-operatively with the Lismore Police to obtain staff interviews, case notes, and other information derived from their investigation;

3. That an investigator external to the New South Wales shires of Richmond, Byron and Tweed, and preferably outside the Northern Rivers Region, be assigned to this case to avoid any possible bias resulting from acquaintance with members of both the victims family and the workplace being investigated;

4. That the assigned investigator has practical experience in investigative approaches and with an understanding of the Mental Health Sector;

5. That WorkCover NSW provide an explanation as to whether the employer was or was not in contravention of the OHS Act 2000;

6. That WorkCover NSW provide a statement with sound reasons (being a ‘non-profit’ organisation is not a sound reason) why proceedings

for the offence have not been instituted in respect of alleged conduct that may constitute such an offence.

Appendix I – After Hours Visits in a Personal Vehicle

As the partner of Michael Corkhill, I (Giovanni Cordeiro) was regularly provided with feedback on the practices at On Track Community Programs. I have factual knowledge that Michael visited the unit of HASI Program client, N (name withheld for privacy reasons) between the hours of approximately 6:00pm and 6:30pm (ie "after hours") for the express purpose of medicating the client.

The task of ensuring the Community Treatment Order (CTO) for the HASI client was adhered to is a duty of the HASI program staff. This is normally carried out as the last duty for the day shift (no night shift is available for the HASI program). The medication provided to N had the effect of causing drowsiness, rendering the client unable to function and consume food after medicating, ie she would fall asleep and not have her evening meal. The HASI program staff were concerned that her failure to eat was affecting her health and quality of life.

In a bid to improve the quality of life for this client, the HASI program staff discussed means to rectify this situation and decided the best option was to medicate her as late as possible, where convenient, after hours and closer to or during her evening meal. Michael had entered Ann in on this arrangement.

Hence, where Michael was concerned, he would:

i. Finish his day's duties in the office at around 4:30pm (more often, later).

ii. On Tuesdays and Wednesdays, Michael would either on his own or with colleagues, head to the local Lismore Workers Club for an hour's session at the gym.

iii. Following the gym session, he would freshen up (which by this time would be between 5:45pm and 6:00pm) and head over to South Lismore in his ***private*** vehicle to attend to N at her unit to ensure that she complied with her CTO. On one occasion, N refused her medication and staff from Community Mental Health were called in, adding to the proof that visits to clients after hours was carried out.

iv. As part of his sign off for the day and a policy on safety at On Track, he would then SMS the mobile of the on-call manager to confirm the completion of his duties. This on-call manager was often Ann Bowen.

Hence, there was an established practice of:

a. Visiting a client (in this case, a HASI client) after hours;
b. Using a personal vehicle;
c. Not indicating on a whiteboard any movements or performing a safety checklist as it was considered a 'drop off';

Information on the medicating of (N) late in the day should be recorded in the client notes. The consistent sign off SMS's to the on-call manager after hours would have alerted the manager, Ann Marie Bowen to the practice. Hence, no argument can be made against her knowledge. In addition, on one occasion due to an unexpected delay, Michael failed to SMS at the expected late time. As the on-call manager, Ann contacted Michael's home phone and the call was received by Michael's partner, Giovanni Cordeiro. Hence, it can be surmised that Ann Bowen was fully aware of the late sign-off.